Anchor Conference Call

AGENDA

January 27, 2014
3:00 - 4:30 p.m. CST

Call-in: 877-226-9790
Access Code: 3702236

1. General Anchor Communication

- Thank you for the work you continue to do for health transformation in Texas.
- An update to the Master project summary list has been completed and will be posted on the waiver website this week.

2. RHP Plan Review

Replacement Projects

- Replacement project were submitted to CMS on January 10th.
- Replacement projects will be in the reporting template and eligible to report late DY 2 achievement and DY 3 beginning in April 2014 (first DY 3 reporting period); payment will be contingent on CMS approval of the project.

DY2 October Reporting Review

- HHSC is reviewing responses to the metrics that were in need of more information (NMI) from the October DY2 reporting review.
- Approval or denial of the additional information submitted is scheduled to be given to providers by February 7th.
- NMI metrics that are approved will be eligible for payment in July 2014.

Phase 4

- HHSC is in the final stages of Phase 4 review.
- Phase 4 feedback should be available today for most RHPs. A few RHPs (4, 7, 9 & 15) will receive their feedback a few days later. HHSC will provide an update as soon as possible and these RHPs will have the same number of days to return responses to HHSC.
- Phase 4 workbooks will be posted on the waiver website, while feedback on Plan Modification requests and Technical Corrections will be emailed to anchors and providers.
- Please review the Phase 4 feedback carefully. In conducting the review, very often providers completed the plan modification summary, but did not complete the changes in the workbook. If at all possible, HHSC staff completed the workbook for the provider. Providers should review carefully to be sure that our staff accurately interpreted the intent of the provider. In cases where we were not able to understand the intent, HHSC requested NMI. We encourage providers to request TA if needed.
- Most plan modifications were approved. If a plan modification seemed a significant variance from the original project, the project was flagged for the potential of identification for midpoint assessment. HHSC will be doing additional review of projects that will be identified for midpoint assessment with the assistance of the monitoring contract that will be finalized this spring.
- This was a very complex task for providers and for the HHSC reviewers. Given multiple HHSC reviewers, the method that the feedback was given may vary with some more detailed than others.

New 3-year projects

- HHSC is currently reviewing the 3-year project proposals. We had communicated a target date for feedback to providers as no later than February 12, 2014 (feedback to RHPs will be staggered). However, this date is likely to change for most RHPs.
- During the last anchor call, we stated HHSC's goal was that projects that are in good shape and that respond fully to the feedback HHSC provides would be able to report in April and that other projects would not be able to report until October.
- Based on how HHSC's review is going (so far, projects are not in as good of shape as we'd expected) we now think that that for most RHPs, 3-year projects will not be able to report until October.
- HHSC is working first on the four RHPs that were able to use very little of their DSRIP allocation in the initial plan submission due to lack of IGT (RHPs 5, 8, 17, 20). HHSC is still shooting for projects in good shape from these four RHPs to be able to report in April.
- We will keep you posted about our review process. For the 3-year projects that are eligible to report in April (will be in the reporting template) payment will be contingent on CMS approval of the project.

DY 4/5 Valuation

- For the providers that received DY4-5 valuation coversheets, thank you for returning them.
- For those projects that received coversheets in December and either accepted a lower valuation or changed QPI/% Medicaid/low income uninsured, HHSC is working to incorporate those changes into your Phase 4 feedback (the January coversheets will not be reflected in the Phase 4 feedback this week).
- For those projects that provided a qualitative justification of why the project should retain the originally proposed valuation, it will take more time for HHSC and CMS to review.
- For RHPs with projects that accepted a lower valuation, the freed up funds for DY4-5 will be available to support the 3-year projects submitted by the RHP that did not have a funding source.

Category 3

- Thank you for your feedback on the state's proposed Category 3 Framework. Major themes of feedback include:
    - For P4R measures, support the use of Priority Population Measures (similar to Cat 4 measures) and the use of stretch activities to compliment selected P4R measures for P4P.
    - Support flexibility around defining outcome denominators to reflect target populations of the Category 1&2 projects as specified through the use of denominator subsets in the final Category 3 Framework
    - Achievement targets that reflect the proportion of the intervention population (Cat 1&2 project QPI) to the measure specifications of the denominator as specified in the Category 3 framework by allowing providers to make this ask in October - *HHSC will continue to work with CMS on parameters.*.
    - Request additional clarification around the risk adjusting associated with the Category 3 PPR's. Risk adjusting will be addressed in the compendium as well as the upcoming webinar to offer guidance to providers on how to use these measures.
    - Concerns around timing and flexibility for selecting measures and establishing baselines. *HHSC will provide guidance to establish baselines and performance benchmarks for P4P measures as part of the outcome measure selection process. In addition, providers can request technical assistance through the Waiver mailbox. HHSC is also working with provider associations to assist to coordinate TA.*
    - Ability to receive incentive payments for outcomes in which the provider is already performing above the benchmark and subsequent payments to maintain high levels of performance – *The Target Setting Methodology approach drafted by CMS specifies that if*

the provider's baseline is already at the High Performance Level (90th percentile), the provider would select a different measure. Given the timing, if a provider believes the measure they have selected, or could select, is already at this level, please submit this information to the waiver mailbox for TA.

  - Request additional clarification on how Cat 4 PPA and PPRs are being calculated for use as Priority Population Measures and process to provide information on these measures.
  - Some providers also made specific requests to move a P4R measure to P4P. *HHSC is compiling that list and will be submitting it to CMS for review.*

- It is still planned that providers will be able to report in April.
- Since the last Anchor call, CMS sent a Counterproposal to the Framework we sent out for comment.
- The major themes of the counterproposal were related to the DY 5 P4R/P4P split, and with the standalone/nonstandalone issue.
- HHSC met again last week with provider organizations (including THOT, UT, TX Council, etc.) to lay out CMS' latest proposal.
- A final round of discussions/negotiations with CMS occurred later in the week, and the Framework has been finalized. That framework and the 'final' menu of measures will be posted to the website this week. The measures will have a designation for P4P or P4R. There are some measures that HHSC is still working on changing from P4R to P4P. Those will be designated with asterisks so we can go ahead and get the menu out.
- The major change in the final framework is 100% P4P in DY 5 for providers that have P4P measures. HHSC did provide feedback to CMS to request 75% P4P/25 P4R based on a recommendation from the meeting with provider organizations; but CMS indicated that approval would be delayed. Therefore, since the Category 3 measures are finalized, we are moving forward with the framework and will continue to work with CMS to see if it will allow for some percentage of P4R in DY 5.
- CMS is requiring 3 non-standalone measures, but allowing to cross domains. Providers will still have to select at least one standalone measure, or 3 non-standalone measures.
- CMS has agreed to 5% improvement over self each year in DY 4 (5% over baseline) and DY 5 (10% over baseline) as the standard for P4P measures that don't have a benchmark.
- CMS has approved the use of denominator subsets based on age, gender, payer, ethnicity/race, facility and co-morbid conditions as appropriate for a measure. Additional guidance will be provided on these subsets and minimum numerator/denominators for measure specifications.
- For flexibility for a provider to request to deviate from the 10% QSMIC gap closing or 5%/10% improvement over self with justification (for instance, if project population is much smaller than the denominator population), the revised framework does allow for approval to deviate from the standard achievement percentages in extenuating circumstances. CMS's concern is that if the percentage improvement is too small, the improvement could be random. HHSC will continue to work with CMS on allowable parameters.

Next Steps

- The revised protocol, companion document and detailed description of measure specifications and benchmarks (we are calling the compendium) is planned to be available to providers in the second week of February as they prepare to make their Category 3 selections.
- Providers will be receiving tools and opportunities for technical assistance in the coming weeks to assist with the selection of their measures.
- HHSC will schedule a webinar in mid to late February.
- We know there are a lot of questions; please send them to the waiver mailbox. We are asking that you hold questions on specific measure specifications until we get the compendium out.
- The date for providers to submit their selected Category 3 selections is now **March 7th** and HHSC will be providing a workbook to facilitate the selection and approval process.

- The plan for DY 3 Reporting is as follows:
    - 50% of the DY3 allocation will be made available for April reporting based on providers submitting a status report, detailing such items as the provider's plan to establish a baseline, general understanding of measure use and TA needs (HHSC will develop a new template for this).
    - The remaining 50% of Cat 3 allocation for DY3 will be reported in October for providers submitting/validating baseline rates (which will be used to establish DY4 and DY5 performance goals). In October reporting, any request to deviate from standard achievement based on proportion of intervention population to the denominator specification of the selected measures would also be proposed. (Based on parameters under development).
    - The PFM and RHP Planning Protocols will be amended with the Category 3 changes.

Category 4

Not new information, but keeping in notes in case helpful.

- We are continuing to work with our Medicaid External Quality Review Organization (EQRO), Institute of Child Health Policy (ICHP) and CMS to finalize the process for the Category 4 PPE domains that the hospitals will be reporting for which HHSC is providing the data. Per the PFM Protocol, the Potentially Preventable Admissions (PPAs) and Potentially Preventable Readmissions (PPRs) are reported beginning in DY 3, and Potentially Preventable Complications (PPCs) are reported beginning in DY 4. Calendar Year 2012 data will be used for the PPAs and PPRs that are reported in DY 3. We will provide additional guidance as soon as available. The plan is still to have data available for the DY 3 April 2014 reporting period.
- The initial data will likely be sent to providers electronically with web-based access to be established at a later date.
- A reporting template will be provided with updates to companion for April reporting.
- For UC only hospitals, we will coordinate with HHSC Rate Analysis Department on how to report. We anticipate that it will be sometime between the April 2014 reporting period and the last quarter of DY 3.
- There are some providers that have stated that they are exempt incorrectly. We will reach out to these providers to make this change. Providers will not be required to submit data if they do not meet the threshold for statistical significance for a particular measure.
- Category 4 guidance can be found on the waiver website at the following link: http://www.hhsc.state.tx.us/1115-docs/category-4-guidance.pdf. If you have specific questions about Cat 4 not covered in the guidance please let us know.

Full Plan Submission

- As discussed, the deadline for resubmitting full plans has been pushed back to April at the earliest. This is due in part because the full plans will include new 3-year projects, which are still under review.
- HHSC sent out requests for Section 1 updates on Friday, January 17th. Updates to contact information for providers, IGT entities and Anchors are due to HHSC by February 7th. The information will help prepare for data seeding the new reporting system.

3. Other Information for Anchors

- HHSC frequently gets asked by the media and other entities for examples of waiver projects that are doing well or that could be highlighted by reporters or in HHSC communications. Rather than having HHSC determine which projects should be highlighted, it would be helpful if each Anchor would send us an updated list of up to 10% of the projects in their RHP (or up to 5 projects if the RHP has fewer than 50 total) that they would like to have showcased. These would be projects that are well underway, are serving the target waiver population (Medicaid and/or low-income uninsured) and provide good examples of how healthcare is being transformed locally under the waiver. Please send your lists to the waiver mailbox by February 7th.

- CMS has confirmed that carryforward of achievement can occur for DY 5 metrics for Category 1 and 2 projects, and for Category 3 outcome measures. Providers will have two opportunities to report for late achievement that occurs from October 1, 2016 to September 30, 2017. This will apply to both 4-year and 3-year projects.

For waiver questions, email waiver staff: TXHealthcareTransformation@hhsc.state.tx.us.
Include "Anchor:" followed by the subject in the subject line of your email so staff can identify your request.